CHAMPVA POLICY MANUAL

CHAPTER 2
SECTION 29.18
TITLE: SURGERY

AUTHORITY: 38 USC 1713; 38 CFR 17.272(a) and 17.272(a)

RELATED AUTHORITY: 32 CFR 199.4(c)(2)(i),(c)(2)(ii),(c)(3)(i),(c)(3)(iii), and (c)(3)(iv)

TRICARE POLICY MANUAL: Chapter 13, Section 3.7

I. EFFECTIVE DATE(S)

The revisions to the procedures for reimbursing multiple surgical procedures (i.e., the elimination of the distinction between related and unrelated procedures) are effective for claims processed on or after August 5, 1988.

II. POLICY

A. Multiple Surgery Procedures.

1. There is to be no distinction made between "related" and "unrelated" conditions in determining the allowable charge for multiple surgical procedures. When multiple surgical procedures are performed during the same operative session, benefits shall be limited to the lesser of the total billed charge or the sum of 100 percent of the prevailing charge for the major surgical procedure and 50 percent of the prevailing charge for the other procedures. The major procedure is that procedure for which the prevailing charge is greatest.

2. The allowable charge for three surgical procedures would be the lower of the sum of the billed charges or the sum of 100 percent of the prevailing charge for the major procedure and 50 percent of the prevailing charge for each of the other two procedures.

3. When two or more procedures are billed separately but are commonly billed as a single procedure, the allowable charge for the combined single procedure is to be used in determining reimbursement for the claim--even though it may be less than the sum of 100 percent of the prevailing charge for the major procedure and 50 percent of the prevailing charge for the other procedure(s).

4. See Chapter 3, Payments, for specific explanation and exceptions.

B. Preoperative Care. Preoperative care rendered in a hospital when the admission is expressly for the surgery is normally included in the global surgery charge. If it is itemized, the charges must be totaled in order to determine the allowable charge. The admitting history and physical is included in the global package. This also applies to routine examinations in the surgeon's office where such examination is performed to assess the beneficiary's suitability for the subsequent surgery.

C. Postoperative Care. All services provided by the surgeon for postoperative complications (e.g., replacing stitches, servicing infected wounds) are included in the global package if they do not require additional trips to the operating room. All visits with the primary surgeon during the 90-day period following major surgery are included in the global package. Relative value studies often specify the number of days during which routine follow-up care can be expected. If a physician itemizes the surgery charge and the charges for routine postoperative care, the total of the charges as a single charge is used to determine the allowable charge.

Note: This rule does not apply if the visit is for a problem unrelated to the diagnosis for which the surgery was performed or is for an added course of treatment other than the normal recovery from surgery. For example, if after surgery for cancer, the physician who performed the surgery subsequently administers chemotherapy services, these services are not part of the global surgery package.

D. Re-operations for Complications. All medically necessary return trips to the operating room, for any reason and without regard to fault, are paid for separately, but at a reduced rate. The payment level for re-operations to deal with complications is set at the value of the global surgery code being performed, if there is a Current Procedure Terminology (CPT) code for the re-operation services. There are several codes describing re-operations necessitated by complications for various body areas. If no separate code exists, however, payment is limited to 50% of the value of the global service originally performed.

E. Second Opinion.

1. Claims for patient-initiated, second-physician opinions pertaining to the medical need for surgery may be paid. Payment may be made for the history and examination of the patient as well as any other covered diagnostic services required in order for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery.

2. In the event that the recommendations of the first and second physician differ regarding the medical need for such surgery, a claim for a patient-initiated opinion from a third physician is also reimbursable. Such claims are payable even though the beneficiary has the surgery performed against the recommendation of the second (or third) physician.

3. Payments for patient-initiated, second (or third) opinions will be based

on the reasonable charges for consultations (and related services) of a comparable level of care.

F. In-office Surgery. Charges for a surgical suite in an individual professional provider's office, including charges for services rendered by other than the individual professional provider performing the surgery and items directly related to the use of the surgical suite, may not be cost-shared unless the suite is a CHAMPVA approved ambulatory surgery center.

*** END OF POLICY ***